U.S. Department of Labor

Office of Administrative Law Judges
800 K Street, NW, Suite 400-N
Washington, DC 20001-8002

(202) 693-7300
(202) 693-7365 (FAX)

Issue Date: 30 November 2004*In the Matter of*:

ANN COLLINS, o/b/o
OLEN COLLINS, Deceased
Claimant,

v.

Case No.: 2003-BLA-00167

KING COAL COMPANY
Employer,

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest

***Appearances*:**

Andrew Delph, Esq.
For the Claimant

Phillip J. Reverman, Esq.
For the Employer

Before: EDWARD TERHUNE MILLER
Administrative Law Judge

DECISION AND ORDER – DENYING BENEFITS

Statement of the Case

This proceeding involves a claim for benefits filed under the Black Lung Benefits Act, as amended, 30 U.S.C. § 901 *et seq.* ("Act"), and the regulations promulgated thereunder.[1] Since

[1] All applicable regulations which are cited in this Decision and Order are included in Title 20, Code of Federal Regulations, and are cited by part or section only. The Director's exhibits are denoted "D-"; Claimant's exhibits, "C-"; Employer's exhibits, "E-"; and citations to the transcript of the hearing, "Tr." Director's Exhibit 1 combines all of the exhibits submitted with the previous claims. The exhibit number appearing within brackets reflects earlier exhibit numbers.

the Miner[2] filed this application for benefits after March 31, 1980, Part 718 applies. This claim is governed by the law of the United States Court of Appeals for the Sixth Circuit, since the Miner was last employed in the coal industry in the Commonwealth of Kentucky. *See Kopp v. Director*, *OWCP*, 877 F.2d 307, 12 B.L.R. 2-299 (4th Cir. 1989); *Shupe v. Director*, *OWCP*, 12 B.L.R. 1-200 (1989) (en banc).

This is the fourth claim for benefits filed by the Miner, Olen Collins. The Miner filed his first claim for benefits under the Act on September 3, 1974. (D-1 [30]). This initial claim was administratively denied on October 10, 1979 because no element of entitlement was established. (D-1 [30]).

The Miner filed a second, duplicate, claim for benefits on October 20, 1987. (D-1 [31]). This claim was initially denied on March 18, 1988. (D-1 [31]). On October 25, 1988, the Deputy Commissioner (now designated the District Director) issued a *Proposed Decision and Order* denying the claim for failure to establish a material change in conditions.[3] (D-1 [30]).

The Miner's third claim was filed on June 11, 1992. (D-1 [1]). The District Director concluded that the Miner had proved a material change in conditions, and entered a *Proposed Decision and Order – Memorandum of Conference* finding the Miner entitled to benefits. (D-1 [27]). This claim was referred to the Office of Administrative Law Judges for a formal hearing. (D-1 [32]). After conducting that hearing on March 24, 1994, Administrative Law Judge Julius A. Johnson, on November 3, 1994, filed a *Decision and Order – Denial of Benefits*. (D-1). On the Miner's appeal to the Benefits Review Board, that tribunal affirmed in part, vacated in part, and remanded the claim to the administrative law judge for further consideration. *Collins v. King Coal Co*., BRB No. 95-0573 BLA (Sept. 12, 1995) (unpub.). (D-1). On remand, Administrative Law Judge Ellin M. O'Shea again denied benefits. (D-1). The denial of benefits was based on a finding that the Miner had failed to establish either pneumoconiosis or total respiratory disability, and thus did not prove a material change in conditions. (D-1). The Miner did not pursue this claim, and the denial became final.

The instant claim was filed on April 27, 2000. (D-2). On August 31, 2000, the District Director made the preliminary determination that the Miner would be entitled to benefits. (D-21). On December 21, 2000, the District Director affirmed this determination. (D-23). The Miner died on November 18, 2000, and the living miner's claim was held in abeyance pending the disposition of a survivor's claim. (*See* D-28, D-30). The survivor's claim was denied, and, at the employer's request, this claim was referred to the Office of Administrative Law Judges on April 22, 2003. (D-35). The formal hearing was conducted before the undersigned in Harlan, Kentucky, on February 4, 2004.[4]

---

[2] This living miner's claim is being pursued on his behalf by his widow, Ann Collins. The Miner died on November 18, 2000. Tr-17.

[3] Although the Miner by letter dated August 16, 1988, had indicated a desire for a hearing, there appears to have been no action taken pursuant to that request.

[4] Claimant's brief has been accepted out of time for good cause shown.

Issues[5]

1. Whether Claimant has proved the existence of pneumoconiosis in the Miner.
2. If so, whether the Miner's pneumoconiosis arose out of his coal mine employment.
3. Whether the Miner was totally disabled.
4. Whether his total respiratory disability, if proved, was due to pneumoconiosis.
5. Whether Claimant has proved a material change in conditions in this subsequent claim.

Findings of Fact and Conclusions of Law

The Miner was born on July 18, 1921. In his claim, he alleged 32 years of coal mine employment, starting in 1938 and leaving the mines in 1982. (D-2). He married Delores Ann Fugate on October 20, 1975, and they were living together at the time of the Miner's death. (Tr. 10). Claimant has one dependent disabled adult daughter, Jennifer, for purposes of augmentation of benefits.

Claimant testified at the formal hearing. She recalled that the Miner's clothing was black after he returned home from the mines. (Tr. 11). He left the mines because of retirement. (Tr. 12). Claimant testified that her husband's "breathing was bad" in the final years of his life, and that "[h]e was on oxygen" about "24-hours a day." He was being treated by a Dr. Mohon. (Tr. 12-14). She recounted that the Miner would run out of breath after climbing four or five steps, or walking about 20 feet on level ground. *Id*. Claimant acknowledged that her husband smoked "maybe a half a pack a day[,]" until quitting six or seven years prior to the hearing. (Tr. 15). The Miner had also suffered a heart attack. *Id*.

Duplicate Claim Evidence

Medical Reports and Opinions

Dr. J. Randolph Forehand

Dr. Forehand examined the Miner at the request of the Department of Labor, and reported on his examination on June 7, 2000. (D-7). The Miner told the doctor that he had worked for 32 years in the mines. The Miner presented a history of wheezing since 1987 and said that he had suffered a heart attack in 1996. He told Dr. Forehand that he had never smoked. The Miner complained to Dr. Forehand of wheezing, a productive cough, edema, orthopnea and dyspnea on walking.

[5] At the formal hearing, counsel for the employer withdrew from contention the issues of timeliness, whether the Miner was a miner, dependency and employer's status as the responsible operator. Counsel also agreed to 15 years of coal mine employment. (Tr. 8). This stipulation is supported by the record.

On physical examination, Dr. Forehand detected on auscultation of the chest "breath sounds of normal quality and distribution." There was no clubbing or edema, and the miner's color was "good perfusion." Dr. Forehand also reviewed the Miner's medications, as well as the results of clinical tests.

The doctor offered the following cardiopulmonary diagnoses: "Possibility raised of coal workers' pneumoconiosis[;]" "hilar lymphodenopathy[,]" and "arteriosclerotic cardiovascular disease[,]" which he attributed to coal dust exposure, possible sarcoidosis and elevated cholesterol. As to the assessment of respiratory disability, Dr. Forehand opined:

> [A] significant respiratory impairment is present. Insufficient residual ventilatory capacity remains to return to last coal mining job. Unable to work. Totally and permanently disabled.

Dr. Forehand continued that the "[C]auses of lung impairment may be multifactorial. 32 years underground coal mining sufficient to injure lungs to this degree. Other interstitial or granulomatous processes may be present."

In a supplemental sheet, Dr. Forehand rendered a definitive conclusion that the Miner suffered from an occupational lung disease derived from his coal mine employment, based on a chest x-ray and other clinical tests. He explained that "the appearance of the chest x-ray is indicative of the level of lung injury (damage). The arterial blood gas and spirogram delineate the degree of impairment and demonstrate the need for continuous oxygen." Dr. Forehand reiterated that the Miner lacked the respiratory capacity to return to his last coal mine job.

Dr. Forehand provided an additional supplemental letter report to the District Director on August 22, 2000. (D-7). Based on an 18 year work history, Dr. Forehand concluded:

> The Miner has airway obstruction of such a degree that he would be unable to work. The Miner reports that he is a lifetime nonsmoker and does not have asthma. In the absence of more common or additional causes of airway obstruction, CWP is the most plausible and medically reasonable and justifiable diagnosis.

The doctor reiterated that the Miner was totally disabled. (D-7).

Dr. Ben V. Branscomb

Dr. Branscomb reviewed specified medical records of the Miner.[6] Dr. Branscomb is board-certified in internal medicine, is currently a Professor Emeritus of the University of Alabama at Birmingham, and has a distinguished academic and clinical career in the fields of internal and pulmonary medicine. He wrote a comprehensive report of his conclusions on July 11, 2003. (E-1).

---

[6] Neither of employer's experts whose reports are contained in the duplicate claim record examined the Miner.

Dr. Branscomb noted a considerable disparity in estimates of the Miner's coal mine employment history from fifteen to thirty-two years, nevertheless deemed sufficient exposure to cause dust-related disorders or impairment. Dr. Branscomb also observed that the Miner had supplied substantially different estimates of cigarette use. Dr. Dahhan recorded a history of one pack per week. Dr. Baker was told one pack per month for 46 years, but that physician had also reported that the Miner began smoking in 1936 and stopped in 1982. The Miner had told Drs. Dineen, Harrison and Forehand that he had never smoked. In view of this divergence of smoking histories, Dr. Branscomb concluded that "one can have little confidence in this history."[7]

Dr. Branscomb acknowledged that simple pneumoconiosis can sometimes be disabling, and that it is a progressive disorder even after the cessation of coal mine dust exposure. The doctor also noted the broad definition of coal workers' pneumoconiosis, and accepted for this analysis that pneumoconiosis can be disabling if it materially worsens a pulmonary or respiratory disability caused by a non-occupational disorder.

---

[7] At the formal hearing, the following testimony was recorded:

[COUNSEL]: Do you know whether your husband smoked?

[CLAIMANT]: Yes, sir, he did.

[COUNSEL]: And, how much did he smoke around you?

[CLAIMANT]: Well, our daughter had allergies and he wasn't allowed to smoke in the house much, so I – I would say maybe a half a pack a day maybe. I'm just saying, for instance, I really don't know.

[COUNSEL]: Okay. And I understand from talking to you earlier that he had quit –

[CLAIMANT]: Yes, he had. Yes, sir.

[COUNSEL]: Do you remember when he quit?

[CLAIMANT]: I don't remember, but he had been quit for – I'd say for the past six or seven years.

(Tr. at 14-15). In the hearing before Administrative Law Judge Johnson that was conducted on March 24, 1994, the Miner said he was not a cigarette smoker, and when asked whether he had ever smoked, claimed that "I might have lit one a couple of times. My dad, he was in a car wreck, and he couldn't roll them or light them. I might have lit a couple for him, but that's all." (Tr. (3-24-94) at 20-21).

Dr. Branscomb recounted that the Miner complained of cough, expectoration and shortness of breath during his black lung examinations, as well as chest pain that was consistent with two heart attacks. The doctor noted that the Miner's medications were appropriate for heart disease, hypertension and asthma. He observed as well that "[t]he record does not contain ongoing documentation by treating physicians to confirm the presence of ongoing chronic pulmonary symptoms."[8]

Dr. Branscomb commented on the clinical testing, specially analyzing separately and in detail the reasons why the spirometric testing by each doctor was invalid. He opined that "Dr. Forehand's pulmonary function tests were invalid even though he repeated them. There are no plateaus and there are marked fluctuations in the rate of air flow. In fact, the tracings show that after almost complete expiration rather than reaching a plateau the flow suddenly increased." He obviously disagreed with Dr. Burki's validation, which provided no explanation or analysis to support his conclusion. Dr. Branscomb opined:

> There are no valid spirograms. Most of the arterial blood gases show mild reduction in oxygen tension. The values are not low enough to produce symptoms, particularly when corrected for barometric pressure. Most of the rest of the values are entirely in keeping with the fact that [the Miner was] 45.7% overweight, severe obesity. The rise in oxygen tension demonstrated by Dr. Harrison also is quite typical for the effects of obesity. The hypercapnia[9] found by Dr. Forehand on 06/07/00 either represents the inadvertent sampling of venous blood or else chronic hypoventilation. This suggests hypoventilation of sleep apnea. It does not suggest a ventilatory impairment. Lung disease sufficiently severe to produce chronic hypercapnia would produce unmistakable and advanced chronic findings which would not have escaped the notice of his regular physicians and which were also not described by the black lung examiners.

(E-7 at 6). He concluded:

> Based on the available medical records there is insufficient objective valid information for concluding CWP is present. In the absence of a confirmation of the abnormalities seen on the last blood gas test and in the absence of a second exercise blood gas test and in the absence of valid spirometry one cannot conclude with a reasonable probability that there is a disabling pulmonary impairment.
>
> Because of the absence of valid objective studies and the absence of ongoing clinical descriptions by practicing physicians of the manifestations of chronic

---

[8] Claimant testified that the Miner had been under the case of Dr. Mohon during the last few years of his life. (Tr. 13-14).

[9] With respect to "hypoxemic hypercapnic respiratory failure," see *Eastover Mining Co. v. Williams*, 338 F.3d 501, 515 n. 17, 22 BLR 2-625 (6th Cir. 2003) (noting physician's explanation that such a condition indicates COPD caused by smoking).

> obstructive pulmonary disease the records do not with reasonable probability justify a diagnosis of significant COPD.

(E-1 at 7).

Dr. Gregory J. Fino

Dr. Fino reviewed the Miner's records for the employer and presented his conclusions in a report dated July 29, 2003. (E-2). He noted, as had Dr. Branscomb, that the Miner's smoking and work histories were significantly inconsistent. Unlike Dr. Branscomb, however, Dr. Fino thought that the Miner suffered from total respiratory disability. He concluded:

> The very significant obstructive abnormality, in conjunction with hypercarbia on the arterial blood gases, all point to a smoking-related abnormality. I believe that this man's disabling respiratory impairment is related to smoking. I do not believe that there is evidence that coal mine dust inhalation played a role in his disabling respiratory impairment.

Dr. Fino also opined that, even assuming that the Miner suffered from pneumoconiosis, "it has not contributed to his disability. He would be as disabled had he never stepped foot in the mines." (E-2 at 10).

X-Ray Evidence[10]

The following x-ray interpretations have been submitted for this duplicate claim:

---

[10] The credentials of interpreters of the x-rays are signified as "B" for a B-reader, "BCR" for a board-certified radiologist, and "B/BCR" for a radiologist who possesses dual qualifications. A physician who is "board-certified" has received certification in radiology by the American Board of Radiology or the American Osteopathic Association. § 718.202(a)(1)(ii)(C). *See Staton v. Norfolk & Western Railway Co*., 65 F.3d 55, 57, 19 BLR 2-271 (6th Cir. 1995). A "B reader" is a physician, often a radiologist, who has demonstrated proficiency in reading x-rays for pneumoconiosis by passing periodically an examination established by the National Institute of Occupational Safety and Health and administered by the U.S. Department of Health and Human Services. *See* § 718.202(a)(ii)(E); 42 C.F.R. § 37.51. Courts generally give greater weight to x-ray readings performed by "B-readers." *See LaBelle Processing Company v. Swarrow*, 72 F.3d 308, 20 BLR 2-76 (3d Cir. 1995). An administrative law judge may properly defer to the readings of the physicians who are both B-readers and Board-certified radiologists. *Roberts v. Bethlehem Mines Corp.*, 8 BLR 1-211 (1985). *See Zeigler Coal Co. v. Director*, *OWCP* [*Hawker*], 326 F.3d 894, 899, __ BLR 2-___ (7th Cir. 2003). Finally, a radiologist's academic teaching credentials are relevant to the evaluation of the weight to be assigned to that expert's conclusions. *See Worhach v. Director*, *OWCP*, 17 BLR 1-105 (1993). An interpretation of "0/0" signifies that a film was read as negative for pneumoconiosis.

Exh. No.	X-ray Date Reading Date	Physician	Qualifications	Film Quality	Interpretation
D-14	6-7-00 6-7-00	Forehand	B	1	1/1[11]
D-15	6-7-00 6-19-00	Sargent	B/BCR	1	no pneumoconiosis
D-16	6-7-00 7-7-00	Barrett	B/BCR	1	no pneumoconiosis

Pulmonary Function Studies[12]

Pulmonary function studies are tests performed to measure obstruction in the airways of the lungs and the degree of impairment of pulmonary function. These tests are also acceptable documentation for a medical opinion diagnosis of pneumoconiosis. The greater the resistance to the flow of air, the more severe the lung impairment. The studies range from simple tests of ventilation to very sophisticated examinations requiring complicated equipment. The most frequently performed tests measure forced vital capacity (FVC), forced expiratory volume in one-second (FEV_1) and maximum voluntary ventilation (MVV). The quality standards for pulmonary function studies performed before January 19, 2001, are found at § 718.103 (2000), while the standards applicable to tests administered after that date are set forth at § 718.103 (2003) and Appendix B.

Ex. No. Date Physician	Age Height	FEV_1 Pre-/ Post	FVC Pre-/ Post	FEV_1/ FVC Pre-/ Post	MVV Pre-/ Post	Qualify	Impression cooperation comprehension tracings

[11] Dr. Forehand checked the box on the x-ray form indicating the film was "completely negative," and also indicated that there were neither parenchymal nor pleural abnormalities consistent with pneumoconiosis. (D-14).

[12] The chart summarizes the results of the pulmonary function studies available in connection with the duplicate claim. "Pre" and "post" refer to administration of bronchodilators. If only one figure appears, bronchodilators were not administered. In a "qualifying" pulmonary study, the FEV_1 must be equal to or less than the applicable values set forth in the tables in Appendix B of Part 718, and either the FVC or MVV must be equal to or less than the applicable table value, or the FEV_1/FVC ratio must be 55% or less. 20 CFR § 718.204(b)(2)(i) (2003). *See Grundy Mining Co. v. Flynn*, 353 F.3d 467, 471 n. 1, __ BLR ___ (6th Cir. 2003).

D-10[13] 6-7-00 Forehand	78 63"	0.76 0.87	1.28 1.80		22 25	Yes Yes	"cooperative with satisfactory efforts." "Expiratory volumes and flows are reduced. Inspiratory and expiratory flow volume curves are not indicative of upper airway obstruction." "Obstructive airway pattern."

Arterial Blood Gas Studies[14]

Blood gas studies are performed to measure the ability of the lungs to oxygenate blood. A defect will manifest itself primarily as a fall in arterial oxygen tension either at rest or during exercise. If the results of a blood gas test at rest do not satisfy Appendix C, then an exercise blood gas test can be offered. Exercise studies are not required if medically contraindicated. § 718.105(b) (2000); § 718.105(b) (2003). The chart summarizes the arterial blood gas studies that have been submitted for the duplicate claim.

Exhibit Number	Date Altitude	Physician	pCO_2 at rest/ exercise	pO_2 at rest/ exercise	Qualify	Impression Comment

[13] Dr. Burki reviewed this test on June 23, 2000, and considered it unacceptable because the equipment did not meet specifications. (D-11). Dr. Forehand's office generated a new set of tracings, because the testing equipment had been improperly calibrated. (D-12). The results were the same, but the tracings were corrected, and Dr. Burki pronounced the test "acceptable," but without any analysis, and no explicit consideration of the characteristics that caused Dr. Branscomb to consider the test results invalid. (D-13).

[14] The quality standards for arterial blood gas studies performed before January 19, 2001, are found at § 718.105 (2000), while the quality standards for tests conducted subsequent to that date are set forth at § 718.105 (2003). A "qualifying" arterial gas study yields values which are equal to or less than the applicable values set forth in the tables in Appendix C of Part 718. Tests with only one figure represent studies at rest only.

D-8	6-7-00 <2999'	Forehand	52	43	Yes	Test deemed "technically acceptable" by Dr. Burki. (D-9) "Evidence of arterial hypoxemia[,]" according to Dr. Forehand. (D-10).

Duplicate Claim Analysis

Because the Miner filed the instant claim on April 27, 2000, more than one year after the final denial of his previous claim, this filing constitutes a duplicate or subsequent claim. The Secretary's regulations that apply to this claim provide that a duplicate claim must be denied on the basis of the prior denial unless Claimant demonstrates that there has been a material change in conditions. § 725.309(d)(2000).

In a duplicate or subsequent claim, the threshold issue is whether all of the new evidence, favorable and unfavorable, supports a determination that the miner has proved at least one of the elements of entitlement previously adjudicated against him. *Sharondale Corp. v. Ross*, 42 F.3d 993, 997-98, 19 B.L.R. 2-10 (6th Cir. 1994). The Board has ruled, in connection with the "material change" analysis for duplicate claims, that the focus of the inquiry is on specific findings made against the miner in the prior claim; an element of entitlement which the prior administrative law judge did not explicitly address in the denial of the prior claim does not constitute an element of entitlement "previously adjudicated against a Claimant." *See Allen v. Mead Corp.*, 22 B.L.R. 1-63 (2000) (*en banc*).

In this case, the Miner's previous claim was denied because of his failure to establish pneumoconiosis or total respiratory disability. Therefore, Claimant must prove either element of entitlement. If the new evidence satisfies Section 725.309(d), and, because this case is governed by the law of the Sixth Circuit, it is also determined that the change rests upon a qualitatively different evidentiary record with regard to the element of entitlement previously adjudicated against the Claimant, the merits of the claim must be reviewed on the record as a whole. *Grundy Mining Co. v. Flynn*, 353 F.3d 467 (6th Cir. 2003); *Tennessee Consolidated Coal Co. v. Kirk*, 264 F.3d 602, 608, 22 B.L.R. 2-288 (6th Cir. 2001); *Cline v. Westmoreland Coal Co.*, 21 B.L.R. 1-69 (1997); *Sharondale Corp*., 42 F.3d at 997.

Total Respiratory Disability

A miner is considered totally disabled if he has complicated pneumoconiosis, 30 U.S.C. § 921(c)(3), § 718.304 (2002), or if he has a pulmonary or respiratory impairment which prevents him from doing his usual coal mine employment and comparable gainful employment, 30 U.S.C. § 902(f), § 718.204(b) and (c) (2002). The regulations provide five methods to prove total disability other than by the presence of complicated pneumoconiosis: (1) pulmonary function studies; (2) blood gas studies; (3) evidence of cor pulmonale with right sided congestive heart failure; (4) reasoned medical opinion; and, in certain limited circumstances, on the basis of

(5) lay testimony. §§ 718.204(b) and (d) (2002). Lay testimony may constitute relevant evidence. *See Madden v. Gopher Mining Co.*, 21 BLR 1-122 (1999). However, a finding of total disability due to pneumoconiosis cannot be made solely on the miner's statements or testimony,. § 718.204(d) (2002). *See Tedesco v. Director, OWCP*, 18 B.L.R. 1-103 (1994).

There is no evidence in the record that the Miner suffered from complicated pneumoconiosis or cor pulmonale. Therefore Claimant has not demonstrated total respiratory disability at § 718.204(b)(1) or (2)(iii). Also Claimant has not demonstrated on the basis of pulmonary function study evidence that the Miner suffered from a total respiratory disability. Although the duplicate claim ventilatory studies produced qualifying results, the invalidations of those studies by Dr. Branscomb are credited on the basis of his detailed critique of Dr. Forehand's tests. Dr. Burki, who found the test administered by Dr. Forehand to be valid, has credentials similar to Dr. Branscomb's, but his validation disclosed no underlying rationale which might refute Dr. Branscomb's opinion regarding the validity of the tests. Dr. Fino did not fault this test, and concluded that the spirometry revealed significant obstruction. Nevertheless, Dr. Branscomb's detailed analysis of this and other pulmonary function studies of record undermines the probative value of Dr. Forehand's ventilatory test, and caused Dr. Branscomb to conclude that there was insufficient evidence to support a finding of disabling pulmonary impairment or significant COPD, or material change in respiratory conditions since 1996.[15]

Claimant, however, has proved on the basis of arterial blood gas evidence developed for the duplicate claim, that the Miner was totally disabled at the time of his death pursuant to § 718.204(b)(2)(ii). Although Dr. Branscomb also faulted the arterial blood gas test, his critique of this test provides an explanation of why it should not be interpreted as evidence of a disabling pulmonary impairment, but is not sufficient to contradict its qualifying status or disprove the existence of total disability or the contrary opinions of Dr. Forehand and Dr. Fino.

The medical opinions of Dr. Forehand and Dr. Fino both assessed totally disabling respiratory impairment. Dr. Fino based his conclusion on the evidence of significant obstructive abnormality and hypercarbia on the arterial blood gases, and was apparently untroubled by the deficiencies perceived by Dr. Branscomb. Dr. Forehand assessed a totally disabling airway obstruction attributed to a variety of causes by a questionable analysis which does not contradict the fact of total disability corroborated by a need for oxygen. Claimant has thus demonstrated

---

[15] The Secretary's regulations allow for the review of pulmonary function testing by experts who can review the ventilatory tracings and determine the validity of a particular test. 20 C.F.R. § 718.103 & Part 718, Appendix B; *Director, OWCP v. Siwiec*, 894 F.2d 635, 636, 13 B.L.R. 2-259 (3d Cir. 1990); s*ee Ziegler Coal Co. v. Sieberg*, 839 F.2d 1280, 1283,11 B.L.R. 2-80 (7th Cir. 1988). Thus, in assessing the probative value of a clinical study, an administrative law judge must address "valid contentions" raised by consultants who review such tests. *See Old Ben Coal Co. v. Battram*, 7 F.3d 1273, 1276, 18 B.L.R. 2-42 (7th Cir. 1993); *Dotson v. Peabody Coal Co.*, 846 F.2d 1134, 1137-38 (7th Cir. 1988); *Strako v. Ziegler Coal Co.*, 3 B.L.R. 1-136 (1981); *Siegel v. Director, OWCP*, 8 B.L.R. 1-156 (1985) (2-1 opinion with Brown, J., dissenting). *Accord*, *Winchester v. Director, OWCP*, 9 B.L.R. 1-177 (1986). In assessing the weight of an expert's review of a clinical test, that expert's credentials must be considered. *See Worley v. Blue Diamond Coal Co.*, 12 B.L.R. 1-20 (1988).

total respiratory disability at § 718.204(b)(2)(iv). In this regard, the testimony of Claimant, who recounted that her husband was on oxygen, is persuasive supporting evidence. *See* § 718.204(d)(3).[16]

Finally, the adjudicator is required to review all relevant evidence, like and unlike, to determine whether a Claimant has established total respiratory disability. *See Shedlock v. Bethlehem Mines Corporation*, 9 B.L.R. 1-195 (1986), *aff'd en banc*, 9 B.L.R. 1-236 (1987). In the absence of contrary probative evidence, evidence which meets one of the § 718.204(b)(2) standards establishes Claimant's total disability. *See Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19 (1987). Review of all relevant evidence submitted with the duplicate claim supports the finding that the Claimant has established that the Miner suffered from a total respiratory disability at the time of his death. Although Dr. Branscomb's opinion constitutes contrary probative evidence, the opinions of Drs. Forehand, Fino and the qualifying arterial blood gas test are more persuasive and probative evidence of total disability, differing qualitatively from the prior proof, to the extent that the Miner's pulmonary or respiratory impairment would have precluded his return to the mines as a ventilation man at the time of his death.[17]

Because Claimant has established total respiratory disability on the duplicate claim with qualitatively different evidence, she has proved a material change in conditions. § 725.309(d); *Sharondale Corp*., 42 F.3d at 997. In view of this finding, the entire evidentiary record must be reviewed to determine whether there is entitlement to benefits. *See Cline v. Westmoreland Coal Co.*, 21 B.L.R. 1-69 (1997).

Medical Evidence Submitted with Prior Claims

X-Ray evidence

The prior claims contain the following x-ray evidence:

Exh. No.	**X-ray Date** **Reading Date**	**Physician**	**Qualifications**	**Film Quality**	**Interpretation**
D-1[30]	8/3/79 8/4/79	Simmons	Bd. Eligible	1	0/1
D-1[30]	8/3/79 9/4/79	Cole	B	"acceptable"	0/0
D-1[31]	12/4/87 12/4/87	Dahhan	B	1	0/1
D-1[31]	12/4/87 12/4/87	Kim	B/BCR	1	Negative

[16] Claimant's testimony would not in itself establish total respiratory disability, but is relevant evidence.

[17] Review of the exertional requirements of this work, as set forth in the Miner's hearing testimony before Administrative Law Judge Johnson, establishes that it was heavy labor.

D-1[17]	8/14/92 8/14/92	Baker	B	2	1/0
D-1[15]	8/14/92 9/11/92	Sargent	B/BCR	2	No pneumo-coniosis
D-1[16]	8/14/92 9/22/92	Ghio	B	1	No pneumo-coniosis
D-1[E-1]	10/4/92 7/22/93	Wiot	B/BCR	2	0/0
D-1[E-2]	3/11/94 3/11/94	Dineen	B	1	0/1
D-1[E-3]	3/22/94 3/22/94	Harrison	B	1	1/0

Medical Opinions

The following medical opinions were submitted for the Miner's prior claims:

Dr. A. Dahhan

Dr. Dahhan examined the Miner on August 3, 1979. (D-1 [30]). He recorded a coal mine employment history of 21 years, and was told by the Miner of a smoking habit averaging one-pack per week. The Miner complained of shortness of breath, wheezing and a productive cough. Dr. Dahhan detected no rales, wheezing or rhonchi on physical examination. There was "[g]ood air entry to both lungs." There was no edema. Dr. Dahhan opined that the pulmonary function study revealed a moderately severe degree of airway obstruction with reasonable ventilatory reserve and normal vital capacity. He concluded that blood gases showed, *inter alia*, a "minimal increase" in the A-a gradient. Dr. Dahhan assessed a mild degree of airway obstruction with no significant effect on blood gas exchange.

Dr. Dahhan examined the Miner again on December 4, 1987. (D-1 [31]). He recorded a history of wheezing and arthritis. The Miner said that he had smoked one pack per month, stopping in 1970. The findings on physical examination of the chest were negative. Dr. Dahhan noted that the Miner was limited to climbing one flight of stairs and lifting 25 to 30 pounds.

Dr. Dahhan's diagnoses included bronchitis and high blood pressure. None of the conditions that were diagnosed were due to coal mine dust exposure, and Dr. Dahhan concluded that the Miner did not have an occupational dust disease. He did say that the Miner suffered a "mild impairment" due to his bronchitis, and a moderate impairment due to ACVD and elevated blood pressure. There was no impairment derived from coal dust exposure.

Dr. Glen Baker

Dr. Baker examined the Miner on August 14, 1992. (D-1 [12]). The Miner related a coal mine employment history of 20 years, working last as a ventilation man, and a smoking habit of

one pack every month for 46 years. He complained to Dr. Baker that he suffered shortness of breath, a productive cough, wheezing and paroxysmal nocturnal dyspnea. Dr. Baker's examination detected decreased breath sounds. The Miner presented with a medical history that included chronic bronchitis, wheezing and high blood pressure. According to Dr. Baker, the Miner was afflicted with coal workers' pneumoconiosis, a moderately severe obstructive defect and a mild resting hypoxemia, all of which were due to coal mine dust exposure. The doctor also noted a possible significant cigarette smoking history.

He explained that the diagnosis of pneumoconiosis was based on the abnormal x-ray and the Miner's history of coal mine dust exposure. The COPD was demonstrated by the pulmonary function study, hypoxemia, and a possible left ventricular dysfunction by history. He attributed the dyspnea to pneumoconiosis acquired from the Miner's coal mine dust exposure, and judged that the COPD was due to the combined effects of smoking and coal dust exposure. The Miner suffered from a moderately severe impairment. Dr. Baker is a board-certified internist and pulmonologist as well as a B-reader. In a brief letter report, Dr. Baker disagreed with a negative rereading of his chest x-ray by Dr. Sargent. (D-1 [13]). On March 25, 1993, Dr. Baker submitted a follow up letter report to counsel, stating his opinion that the Miner was totally disabled due to his pneumoconiosis. (D-1 [Claimant. Ex-1]).

Dr. Baker also testified in a deposition that was recorded on March 28, 1994. (D-1 [E-4]). Dr. Baker agreed that chronic obstructive pulmonary disease may be due to cigarette smoking. *Id.* at 8. He further testified that, had the Miner not worked in the mines, the pulmonary function study results would be consistent with a condition due to smoking. Dr. Baker also allowed that the Miner's left ventricular dysfunction could be the cause of the Miner's "nocturnal symptoms." *Id*. at 9. He also admitted that the Miner's symptoms were consistent with long-term cigarette smoking. In this instance, he noted that the cigarette smoking history provided by the Miner amounted to fewer than two pack years. He appeared to be uncertain about the precise history. Dr. Baker stated that "if his smoking history is as minimal as he alleges, I think probably the more damaging may be his coal dust exposure, but I can't proportion that to a percentage." *Id*. at 17. He opined that the degree of smoking that was admitted would be an unlikely cause of the Miner's total respiratory disability. *Id*. at 17.

Dr. Shawn S. Fugate

On March 8, 1994, Dr. Fugate wrote a letter "To Whom it May Concern," stating that the Miner did not wish further pulmonary function testing, due to the strain. He suggested that such testing would be contraindicated because the Miner was then taking medication that might interfere with the accuracy of the tests. (D-1 [Claimant. Ex-1]).

Dr. John F. Dineen

Dr. Dineen examined the Miner on March 11, 1994. (D-1 [E-2]). The Miner related a work history of 15 years, and said that he was a non-smoker. He told the doctor that he had shortness of breath and a productive cough, and that he used an inhaler and Theo-24. Dr. Dineen was told there was no history of asthma or heart problems. Dr. Dineen detected no rales, wheezes or rhonchi on physical examination. There was a "markedly decreased air entry to both

lungs." The doctor interpreted a chest x-ray as showing a classification of 0/1, which is not proof of pneumoconiosis under the applicable regulations. He also administered clinical tests – a ventilatory study and arterial blood gas test. He considered the ventilatory study to be inadequate due to poor effort. The blood gas test showed minimal hypoxemia. Dr. Dineen opined that the Miner suffered from no lung injury as a result of his coal mine dust exposure.

Dr. John M. Harrison

The Miner was seen by Dr. Harrison on March 22, 1994 for a Kentucky Workers' Compensation evaluation. (D-1 [E-3]). He told the doctor of working 25 years in the mines, and denied that he had ever smoked. Dr. Harrison noted clear lungs on physical examination, but the Miner complained of shortness of breath, wheezing and a productive cough. His past medical history included emphysema and hypertension. The doctor saw early x-ray signs of pneumoconiosis, and opined that the Miner's asthma would preclude further work in the mines. The doctor also observed that the Miner was obese, 63 inches tall and weighing 200 pounds. Dr. Harrison is a B-reader and is board-certified in internal medicine.

Dr. Harrison thought that the ventilatory test was invalid, but nonetheless suspected the presence of an obstructive defect because lung volumes revealed significant air trapping. The doctor opined that asthma was the cause of the pulmonary function study results, and thought that the Miner would not be able to return to his former coal mine employment from a pulmonary standpoint. The doctor attributed this disability to an underlying asthma because he would not expect this type of defect in coal workers' pneumoconiosis.

Pulmonary Function Tests

The ventilatory studies that were submitted with the Miner's prior claims include the following tests:

Ex. No. Date Physician	Age Height	FEV_1 Pre-/ Post	FVC Pre-/ Post	FEV_1/ FVC Pre-/ Post	MVV Pre-/ Post	Qualify	Impression cooperation comprehension tracings
D-1 [D-30] 8-3-79 Dahhan	58 64"	1.65	3.03	34%	(MBC) 90	No	good cooperation/comprehension, tracings attached
D-1 [D-31] 12-4-87 Dahhan	66 64"	1.52	2.50		43	No	Invalidated by Dr. Kraman, who is board-certified in internal and pulmonary medicine.
D-1 [12] 8-14-92 Baker	71 63"	1.19	2.70	44%	52	Yes	Invalidated by Dr. Kraman. (D-1 [11]).

D-1 [E-3] 3-3-94 Harrison	72 63"	1.06	1.47	72%		Yes	Spirometry invalid
D-1 [E-2] 3-11-94 Dineen	72 63"	1.08	1.98		31	Yes	Inadequate due to lack of best effort; Miner concerned with black out spell

Arterial Blood Gas Tests

The following arterial blood gas tests were submitted in connection with the Miner's prior claims:

Exhibit Number	Date Altitude	Physician	pCO_2 at rest/ exercise	pO_2 at rest/ exercise	Qualify	Impression Comment
D-1 [30]	8-3-79	Dahhan	32	79	No	
D-1 [31]	12-4-87	Dahhan	39	67.9	No	not exercised due to hyperventilation
D-1 [14]	8-14-92	Baker	38	71	No	resting hypoxemia
D-1 [E-2]	3-11-94	Dineen	44	64.5	No	minimal hypoxemia
D-1 [E-3]	3-22-94	Harrison	43 43	59 66	Yes No	

Discussion -- Merits of Entitlement

Total Respiratory Disability

Review of the entire record establishes that the Miner was totally disabled at the time of his death. However, the prior claims contain largely invalid and non-qualifying clinical tests, and Claimant has not demonstrated total respiratory disability on the record of prior claims by pulmonary function test results or actual blood gas test results under §§ 718.204(b)(2)(i), (ii). Total disability has been established on this claim by physicians' opinions pursuant to § 718.204(b)(2)(iv). The more recent medical evidence is credited as the most probative evidence of the nature and extent of the Miner's impairment, and establishes total respiratory disability on the duplicate claim.[18] *See Cooley v. Island Creek Coal Co.*, 845 F.2d 622, 624, 11

[18] The previous ventilatory study and arterial blood gas study evidence does not, on balance, demonstrate total respiratory disability. Drs. Baker and Harrison, however, opined that the Miner's pulmonary or respiratory impairment would preclude further coal mine employment. *See* (D-1 [D-12], D-1 [E-3]). In 1987, Dr. Dahhan assessed The Miner's pulmonary impairment as "mild," although he did not attribute this to coal mine dust exposure. (D-1 [D-31]). These assessments tend to corroborate a finding of total respiratory disability when considered in

B.L.R. 2-147 (6th Cir. 1988); *see also Coffey v. Director, OWCP*, 5 B.L.R. 1-104 (1982). Drs. Baker and Harrison have found total respiratory disability.

Weighing all of the evidence, like and unlike, supports a finding of total respiratory disability established at § 718.204(b). Despite the contrary probative evidence that consists of the nonqualifying and nonconforming clinical tests, the opinions of these physicians, in concert with the most recent assessments, support a finding of total respiratory disability.

Existence of Pneumoconiosis

Because this claim arises within the territorial jurisdiction of the Sixth Circuit, Claimant may establish that the Miner had pneumoconiosis under any one of the alternate methods set forth at § 718.202(a). *See Furgerson v. Jericol Mining, Inc.*, 22 B.L.R. 1-216 (2002) (en banc); s*ee also Eastover Mining Co. v. Williams*, 338 F.3d at 509. Section 718.202(a) (2002) provides that a finding of the existence of pneumoconiosis may be based on (1) chest x-ray, (2) biopsy or autopsy, (3) application of the presumptions described in § 718.304 (irrebuttable presumption of total disability if there is a showing of complicated pneumoconiosis), § 718.305 (not applicable to claims filed after January 1, 1982) or § 718.306 (applicable only to deceased miners who died on or before March 1, 1978), or (4) a physician exercising sound medical judgment based on objective medical evidence and supported by a reasoned medical opinion.

There is no evidence that the Miner had a lung biopsy, and no autopsy has been performed. None of the presumptions set forth at §§ 718.304-306 apply. Proof of the existence of pneumoconiosis, therefore, must be based upon the chest x-rays and medical opinions of record. §§ 718.202(a)(1), (4).

The probative value of the x-ray interpretations of record depend upon the qualifications of the medical expert readers. Rigid deference to numerical superiority of x-ray readings or a "later evidence" rule in assigning weight to conflicting x-ray evidence must be avoided. *See Consolidation Coal Co. v. Director*, *OWCP* [*Sisson*], 54 F.3d 434, 438, 19 BLR 2-155 (7th Cir. 1995); *Bailey v. U.S. Steel Mining Co*., 21 BLR 1-152 (1999) (en banc). A "qualitative," as well as a quantitative evaluation of the x-ray readings must be employed to determine whether Claimant has demonstrated the existence of pneumoconiosis on the basis of x-ray evidence. *See Woodward v. Director, OWCP*, 991 F.2d 314, 321, 17 BLR 2-77 (6th Cir. 1993).

Claimant has not established on the basis of x-ray evidence that the Miner had pneumoconiosis. The film taken on August 3, 1979, was not interpreted as positive for pneumoconiosis. The positive reading of the August 14, 1992 x-ray by Dr. Baker, a B-reader, is overcome by the contrary interpretations of this film by Drs. Sargent and Ghio. Dr. Sargent is dually-qualified as both a B-reader and board-certified radiologist. Dr. Ghio is, like Dr. Baker, a B-reader. Dr. Wiot's negative interpretation of the October 4, 1992, film, and Dr. Dineen's "0/1"

---

concert with the most recent opinions from Drs. Fino and Forehand. Dr. Branscomb's opinion does not necessarily refute these findings, as he found the invalid spirometry, and the conspicuously unreliable employment and smoking histories, to be an insufficient basis on which to assess pulmonary disability.

interpretation of the March 11, 1994 x-ray, are not proof of pneumoconiosis. The most recent film, taken on June 7, 2000, and read as positive by Dr. Forehand, a B-reader, was reread as negative for pneumoconiosis by two dually-qualified radiologists, and so does not demonstrate the presence of pneumoconiosis. Dr. Harrison's uncontradicted interpretation of the x-ray taken on March 22, 1994, is the sole positive film of record.

A qualitative, as well as "quantitative," approach to this evidence, *see Woodward v. Director, OWCP*, 991 F.2d at 321, given the weight of the negative x-ray evidence, *see Edmiston v. F&R Coal Co.* 14 BLR 1-65 (1990); s*ee also Napier v. Director, OWCP*, 890 F.2d 669, 671, 13 BLR 2-117 (4th Cir. 1989), and the superior credentials of the readers, *see Worhach v. Director, OWCP*, 17 BLR 1-105 (1993), establishes that the x-ray evidence as a whole does not demonstrate the existence of pneumoconiosis pursuant to § 718.202(a)(1). § 718.202(a)(1). Because Claimant bears the burden of proof, the x-rays as a whole do not establish the existence of pneumoconiosis. *See generally Greenwich Collieries v. Director, OWCP*, 990 F.2d 730, 17 BLR 2-64 (3d Cir. 1993), *aff'd* 512 U.S. 267 (1994).

Medical Opinions

Claimant has not established the existence of pneumoconiosis on the basis of the medical opinion evidence of record. § 718.202(a)(4). The existence of pneumoconiosis may be proved, notwithstanding a negative x-ray, if a physician, exercising sound medical judgment finds that the miner has pneumoconiosis as defined in § 718.201. Any such finding must be based on objective medical evidence, such as arterial blood gas tests, physical performance tests, physical examination, and medical and work histories. Such a finding must be supported by a reasoned medical opinion. Pneumoconiosis is defined broadly under the Act, and any pulmonary or respiratory impairment significantly related to, or substantially aggravated by, the Miner's coal mine dust exposure qualifies as the disease. *See generally Southard v. Director, OWCP*, 732 F.2d 66, 6 BLR 2-26 (6th Cir. 1984). Obstructive lung disease may constitute pneumoconiosis under the Act, *see Kline v. Director, OWCP*, 877 F.2d 1175, 1178, 12 BLR 2-346 (3d Cir. 1989), provided it is proved to have been significantly related to or substantially aggravated by a miner's coal mine dust exposure. *See Stiltner v. Island Creek Coal Co.*, 86 F.3d 337, 341, 20 BLR 2-246 (4th Cir. 1996); *see generally* 65 Fed. Reg. 79943 (Dec. 20, 2000) (citing cases).

An Administrative Law Judge may properly discount a physician's opinion as to the causation of a miner's respiratory or pulmonary impairment when it is based on an inaccurate understanding of the miner's smoking history. *See Bobick v. Saginaw Mining Co.*, 13 B.L.R. 1-52 (1988); *Maypray v. Island Creek Coal Co.*, 7 B.L.R. 1-683 (1983). An opinion may also be discounted where it is based in part on an inaccurate medical history. *See Risher v. Director, OWCP*, 940 F.2d 327, 330-31, 15 B.L.R. 2-186 (8th Cir. 1991) (discounting opinion based on inaccurate medical history).

In this case the Miner's cigarette smoking history is problematic. He testified before Judge Johnson that he was essentially a non-smoker, told physicians in his later examinations that he had never smoked, and related in earlier medical examinations a smoking history that appears minimal. Notwithstanding, Dr. Fino, after reviewing the specified medical file,

suspected that smoking was a cause of the Miner's disabling respiratory "abnormality." (E-1). Dr. Branscomb thought that there was no reliable smoking history. And Dr. Baker indicated that the Miner's minimal characterization of his smoking history was suspect. (D-1 [E-4 at 17]).

Claimant testified credibly that the Miner had smoked cigarettes at the estimated rate of about one-half pack per day until approximately seven years prior to his death and that, because their daughter suffered from allergies, the Miner was required to go outside to smoke. (Tr. at 14-15). Thus, the Miner clearly smoked, probably not heavily, over a substantial period and was neither consistent nor truthful about his smoking history to doctors or adjudicators. This fact and Dr. Branscomb's critique of the pulmonary function testing of record render the medical opinions of record unpersuasive as evidence of pneumoconiosis as that disease is broadly defined in the Act. Dr. Branscomb questioned various aspects of Dr. Forehand's assessments in detail. Dr. Forehand apparently did not question or attempt to verify the history supplied by the Miner that he was a lifetime nonsmoker and did not have asthma, although the record shows that the former conflicted with prior disclosures to doctors and the latter was at lest questionable since Dr. Harrison diagnosed it, Dr. Fino referred to it as part of the medical history, and Dr. Branscomb noted a positive family history and past medical history of the Miner.

The opinions of Drs. Baker and Forehand are otherwise flawed. Dr. Forehand's initial diagnostic opinion was equivocal in that he noted only a "[p]ossibility raised of coal workers' pneumoconiosis." The x-rays upon which Drs. Baker and Forehand relied were reread as negative by radiologists with superior credentials. Although both physicians are B-readers, the qualifications of Drs. Barrett and Sargent, who are dually-qualified as a B-readers and board-certified radiologists, are superior and entitled to greater weight. Although Dr. Harrison diagnosed pneumoconiosis by x-ray and attributed the Miner's disability to asthma, he did not attribute the Miner's asthma to coal mine dust exposure. While a diagnosis of pneumoconiosis in a medical opinion may be sufficient notwithstanding a negative x-ray, *see Taylor v. Director, OWCP*, 9 BLR 1-22 (1996), where x-ray evidence constitutes an apparent major part of the physician's documentation, his opinion may be entitled to diminished probative weight if that film has been reread as negative. *See Worhach v. Director, OWCP, 17 BLR 1-105 (1993); see generally Director, OWCP v. Rowe*, 710 F.2d 251, 255 n. 6, 5 BLR 2-99 (6th Cir. 1983). Dr. Harrison's diagnosis of pneumoconiosis appears to be a restatement of his x-ray interpretation.

Drs. Forehand's and Harrison's opinions also have significantly reduced probative weight because they depended on the false assumption that the Miner was a non-smoker. *See Risher v. Director, OWCP*, 940 F.2d 327, 330-31 (8th Cir. 1991). Although Dr. Baker recorded some cigarette smoking history, and was told about a one pack per month habit, Claimant's credible testimony undermines the credibility of Dr. Baker's history.[19] Finally, evidence of cigarette use bolsters Dr. Fino's opinion that smoking was a primary cause of the Miner's pulmonary abnormality. Dr. Branscomb's critique of Dr. Forehand's ventilatory testing, one of the primary

[19] A specific finding with respect to the extent of the Miner's cigarette smoking history is elusive. The Miner's inconsistent disclosures and the testimony by a competent witness that he might have smoked as much as one-half pack per day contradict the suggestion that he had never smoked or had a minimal habit upon which some medical opinions depended to their detriment in probative value.

factors that led Dr. Forehand to diagnose pneumoconiosis, also militates against the credibility of Dr. Forehand's assessment and the existence of coal workers' pneumoconiosis. These opinions, taken as a whole, are insufficient to carry Claimant's burden of proof under § 718.202(a)(4) to establish the existence of coal workers' pneumoconiosis.

Conclusion

Because of the finding that the Miner suffered from a totally disabling pulmonary or respiratory impairment Claimant has proved a material change in conditions. On the record as a whole, however, Claimant has failed to establish the existence of pneumoconiosis, a necessary element of entitlement, and thus is not entitled to benefits under the Act.

ORDER

The claim of Ann Collins, on behalf of the Miner Olen Collins, for benefits under the Act is denied.[20]

A
EDWARD TERHUNE MILLER
Administrative Law Judge

Washington, D.C.

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within 30 (thirty) days from the date of this Decision by filing a Notice of Appeal with the **Benefits Review Board at P.O. Box 37601, Washington, D.C. 20013-7601**. A copy of this Notice of Appeal must also be served on Donald S. Shire, Associate Solicitor for Black Lung Benefits, 200 Constitution Avenue, N.W., Room N-2117, Washington, D.C. 20210.

[20] The award of an attorney's fee under the Act is permitted only in cases in which the Claimant is found to be entitled to benefits. Section 28 of the Longshore and Harbor Workers' Compensation Act, 33 U.S.C. § 928, as incorporated into the Black Lung Benefits Act, 30 U.S.C. § 932. Since benefits are not awarded in this case, the Act prohibits the charging of any fee to the Claimant for services rendered to him in pursuit of this claim.